

Aviation Psychiatry Update

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NAMI Psychiatry Department Head

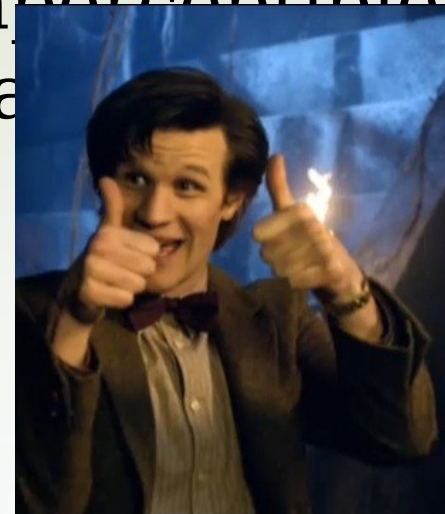


U. S. Naval Aeromedical Conference
15 JAN 15



Disclosure

- ✧ Dr. McDonald has no relevant (or irrelevant) financial relationships to disclose.
- ✧ There will be an almost imperceptible mention of off-label medication.
- ✧ Bow ties are (still) cool.



Objectives

- ✧ Discuss current staffing NAMI Psychiatry staffing, and some upcoming changes
- ✧ Update on command directed aerospace psychiatric evaluations by NAMI Psychiatry (those formerly known as “Boxer” cases)
- ✧ Discuss NAMI policy pertaining to psychotropic medicine use in the aviation environment

Objectives

- ✈ Review relevant DoD administrative guidelines/instructions
- ✈ Review guidance for Alcohol waiver packages
- ✈ Discuss issues surrounding flight deck personnel and psychotropic medication

Objectives

- ✧ Discuss Aeromedical Electronic Resource Office (AERO) system for submission of waiver requests
- ✧ Briefly discuss recent changes in psychiatric taxonomy (DSM-5) and aeromedical impact of those changes

NAMI Psychiatry Staff

- CAPT (Ret.) Tony McDonald, MC USN
 - Department Head
 - Aerospace and Addiction Psychiatrist
 - Naval Flight Surgeon

- LCDR Tara Walker, MC USN
 - Aerospace Psychiatrist and Naval Flight Surgeon

- CDR Arlene Saitzyk, MSC USN
 - Aerospace Clinical Psychologist

NAMI Psychiatry Staff

- ✈ CDR (Ret.) Shirley Ellis, MSC USN
 - Former Marine Intel Officer
 - Clinical Psychologist
 - Uniformed NAMI Staff Psychologist 1997-2003

- ✈ Laroice Keligond
 - NAMI Psychiatry Division Secretary

NAMI Psychiatry Staff: Transitions

- ✈ LCDR Walker outbound (Summer 2015)
 - Transferring to CIVLANT
- ✈ LCDR Dan DeCecchis inbound (Fall 2015)
 - Winged Naval Flight Surgeon in 2008
 - Operational tour with 1st MAW, Futenma
 - Currently staff psychiatrist at NMC Portsmouth

Command Directed Mental Health Evaluations



Command Directed Mental Health Evaluations

Applicable Directive:

- DoD Instruction 6490.04 [04 MAR 2013]
 - “Mental Health Evaluations of Members of the Military Services”
 - “Reissues” DoD Instruction 6490.4
 - “Incorporates and cancels” DoD Directive 6490.1
 - Implements section 1090a of Title 10, USC and section 711(b) of Public Law 112-81, the National Defense Authorization Act for Fiscal Year 2012

Command Directed Mental Health Evaluations

No longer in use:

✈ SECNAV Instruction 6320.24A
[16FEB1999]

- “Mental Health Evaluations of Members of the Armed Forces”
- Still awaiting Navy implementing instruction to match DoD Instruction 6490.04

Command Directed Mental Health Evaluations

Key points:

- Senior enlisted member may be designated by CO for ordering emergency CDE of junior
- A commissioned officer may be designated by CO to refer officer junior in rank
- No more letters
- Required training has yet to be developed

Command Directed Mental Health Evaluations

The “ART” of referral: 3 simple steps for CO:

- Advise member there is no stigma associated with obtaining mental health services
- Refer member to MHP, providing both name and contact info
- Tell member the date, time, and place of scheduled MHE

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Psychotropic Medicine Use In the Aviation Environment

- ✧ There have been no changes in Naval Aeromedical Policy

- ✧ Psychotropic pharmacotherapy is NOT compatible with Duty Involving Flying
 - Includes medicines used for tobacco cessation (i.e., bupropion (Zyban®), Wellbutrin®) and varenicline (Chantix®) other than nicotine replacement
 - Applies equally to all flying classes (I, II and III) and Service Groups

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Command Notification

- ✈ DoD Instruction 6490.08 [17AUG2011]
 - “Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members”
- ✈ Establishes policy, assigns responsibilities, and prescribes procedures for healthcare providers for determining command notification requirements

DoDI 6490.08 [17AUG2011]

- Provides guidance for balance between patient confidentiality rights and commander's right to know for operational and risk management decisions
- DoD measure aimed at fostering a culture of support in the provision of mental health care
- Dispel stigma of seeking care for mental health and substance misuse issues

DoDI 6490.08 [17AUG2011]

- ✈ Healthcare providers shall follow a presumption that they are NOT to notify a commander when a member obtains mental health or substance use education services
- UNLESS the presumption is overcome by one of the notification standards (listed on following slides)

DoDI 6490.08 [17AUG2011]

b. Healthcare providers shall notify the commander concerned when a Service member meets the criteria for one of the following mental health and/or substance misuse conditions or related circumstances:

(1) Harm to Self. The provider believes there is a serious risk of self-harm by the Service member either as a result of the condition itself or medical treatment of the condition.

(2) Harm to Others. The provider believes there is a serious risk of harm to others either as a result of the condition itself or medical treatment of the condition. This includes any disclosures concerning child abuse or domestic violence consistent with DoD Instruction 6400.06 (Reference (f)).

(3) Harm to Mission. The provider believes there is a serious risk of harm to a specific military operational mission. Such serious risk may include disorders that significantly impact impulsivity, insight, reliability, and judgment.

(4) Special Personnel. The Service member is in the Personnel Reliability Program as described in DoD Instruction 5210.42 (Reference (g)), or is in a position that has been pre-identified by Service regulation or the command as having mission responsibilities of such potential sensitivity or urgency that normal notification standards would significantly risk mission accomplishment.

DoDI 6490.08 [17AUG2011]

(5) Inpatient Care. The Service member is admitted or discharged from any inpatient mental health or substance abuse treatment facility as these are considered critical points in treatment and support nationally recognized patient safety standards.

(6) Acute Medical Conditions Interfering With Duty. The Service member is experiencing an acute mental health condition or is engaged in an acute medical treatment regimen that impairs the Service member's ability to perform assigned duties.

(7) Substance Abuse Treatment Program. The Service member has entered into, or is being discharged from, a formal outpatient or inpatient treatment program consistent with DoD Instruction 1010.6 (Reference (h)) for the treatment of substance abuse or dependence.

(8) Command-Directed Mental Health Evaluation. The mental health services are obtained as a result of a command-directed mental health evaluation consistent with DoD Directive 6490.1 (Reference (i)).

(9) Other Special Circumstances. The notification is based on other special circumstances in which proper execution of the military mission outweighs the interests served by avoiding notification, as determined on a case-by-case basis by a health care provider (or other authorized official of the medical treatment facility involved) at the O-6 or equivalent level or above or a commanding officer at the O-6 level or above.

DoDI 6490.08 [17AUG2011]

c. In making a disclosure pursuant to the circumstances described in subparagraphs 1.b.(1) through 1.b.(9) of this enclosure, healthcare providers shall provide the minimum amount of information to satisfy the purpose of the disclosure. In general, this shall consist of:

(1) The diagnosis; a description of the treatment prescribed or planned; impact on duty or mission; recommended duty restrictions; the prognosis; any applicable duty limitations; and implications for the safety of self or others.

(2) Ways the command can support or assist the Service member's treatment.

d. Healthcare providers shall maintain records of disclosure of protected health information consistent with Reference (b).

Deployment Limiting Conditions/Medications

- ✈ DoD Instruction 6490.07 [05 February 2010]
 - “Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees”
 - No psychotic and/or bipolar disorders
 - “3 months of demonstrated stability”

- ✈ BUMED Memo 13 November 2013
 - Substance use disorders “should not be deployed” if it would interrupt active treatment
 - Should not deploy if determined to “be at risk for suicide or violence towards others”

DSM-5 IS HERE!

- ✧ Published 18 May 2013
- ✧ Superseded DSM-IV-TR
- ✧ Very controversial!



1980

1987

1994

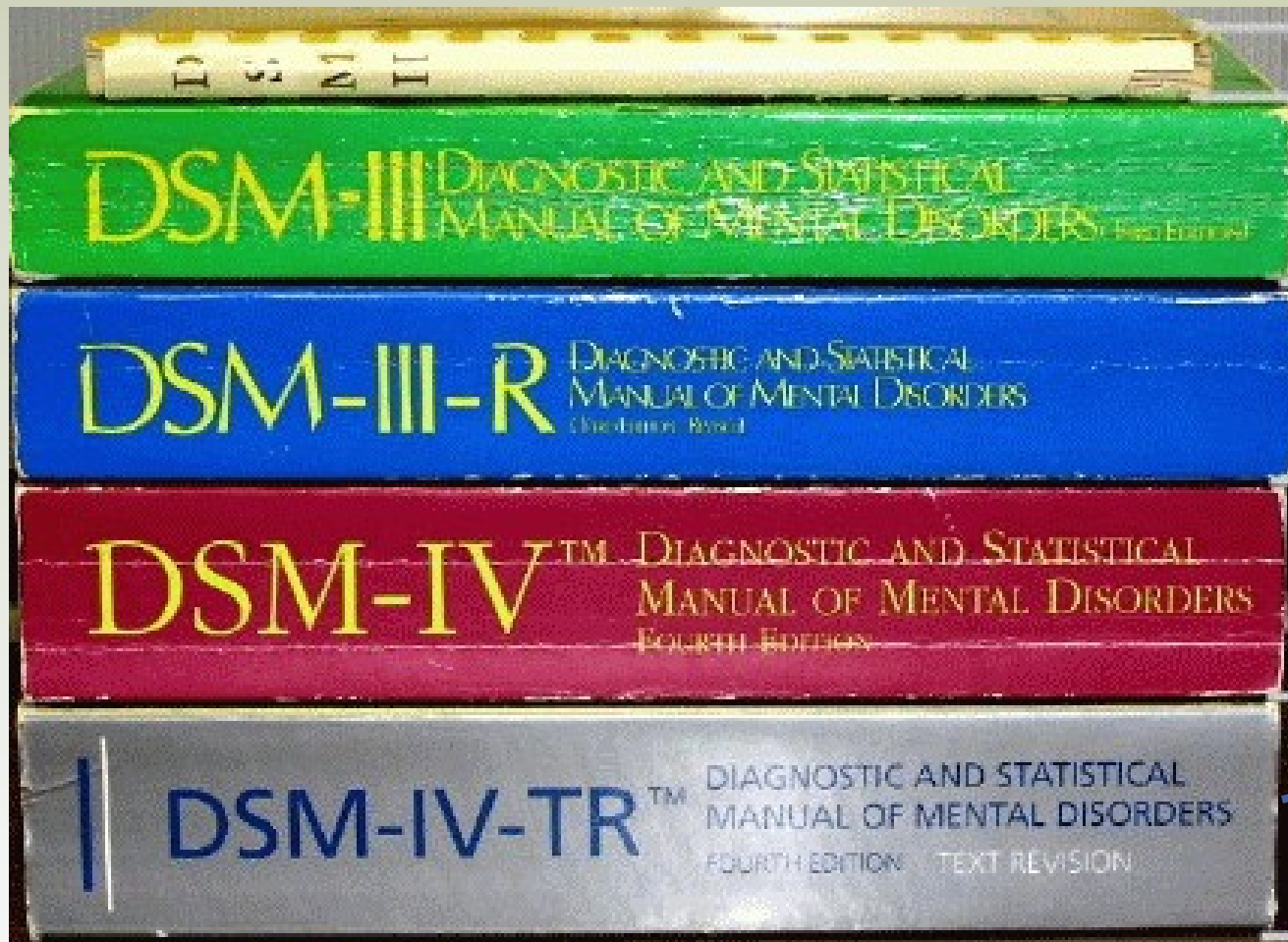
2000

2013

1952

1968

DSM-I: 130 pages; 106 diagnoses



**134 pages
182 diagnoses**

**494 pages
265 diagnoses**

**567 pages
292 diagnoses**

**886 pages
297 diagnoses**

**943 pages
297 diagnoses**

DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS

FIFTH EDITION

DSM-5

AMERICAN PSYCHIATRIC ASSOCIATION

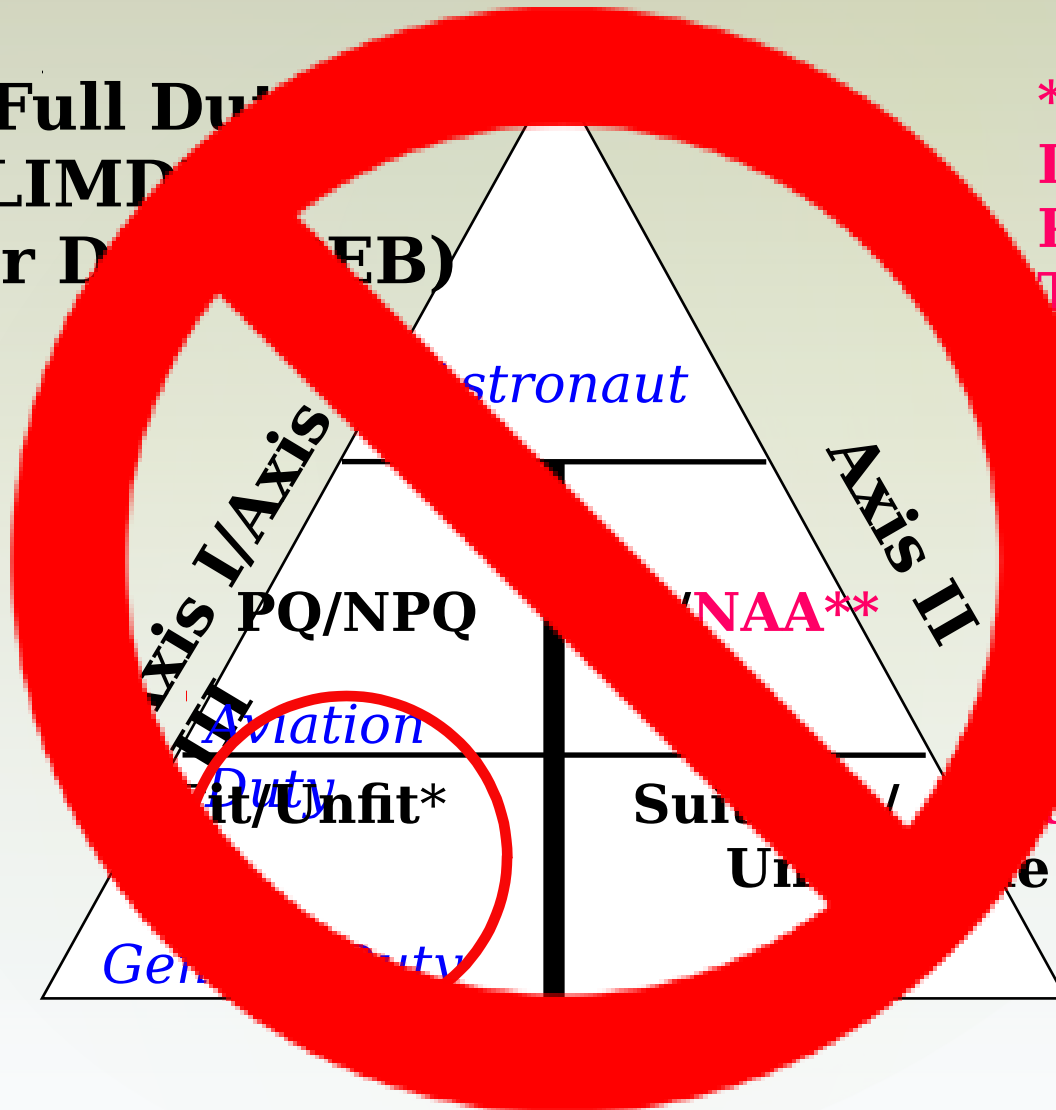
947 pages
333 diagnoses

Aeromedical disposition: DSM-III

IV →

*Fit for Full Duty
 *Fit for LIMDP
 *Unfit for Duty (EB)

**Personality Disorders or Personality Traits that are maladaptive and impair flight safety, mission completion, or aircrew coordination



DSM 5: What's Gone

- Multiaxial system
 - Simple list of 20 chapters for disorder categories
 - ARWG implications
- “NOS” diagnoses within categories
 - Now “Unspecified”
- Bereavement exclusion in MDD
- Mixed anxiety-depression not added

DSM 5: What's New

➤ Biomarkers

- Polysomnography for sleep disorders
- CSF hypocretin for narcolepsy

➤ Binge Eating Disorder

➤ Premenstrual Dysphoric Disorder

DSM 5: PTSD

- “Trauma and Stress-Related Disorders”
- Criteria changes
 - Removal of “fear, helplessness, or horror”
 - Split “avoidance” into two clusters of symptoms
 - Avoidance
 - Changes in thought and mood (emotional numbing)
 - Separate categories for children and adults
 - 9 dimensional assessments added
- Posttraumatic Stress “Injury”
disapproved
 - Proposed by veterans’ groups as less pejorative

DSM 5: SUD

➤ Substance Use Disorder

- No distinction between “Abuse” and “Dependence”
- Craving criterion

➤ Gambling Disorder Added

- Other addictions considered but not added
- Sex, food, caffeine, the Internet

➤ The word “addiction” not used

➤ Internet Gaming Disorder in “Section III”

- Equivalent to DSM-IV Appendix B “For Further Study”

Waiver Guide Overhaul

- ✧ ARWG Section 14 (Psychiatry) Updated in July 2014 to conform to DSM-5 nomenclature
- ✧ A couple of major changes, lots of minor
- ✧ Includes general guidelines and some useful references
- ✧ Updates will be ongoing

Waiver Guide Changes

- Subsection headings match DSM-5 Chapters
- No waivers for Brief Psychotic Disorders
 - Substance/Medication-Induced Psychotic Disorder & Psychotic Disorder Due to Another Medical Condition still psychiatrically NCD (similar exclusion for all)
- New Eating Disorders section
 - All CD for DIF, considered case by case, 1-yr minimum
 - NAMI Psychiatry eval required

Waiver Guide Changes

➤ Adjustment Disorders

- As per DSM-5, now with ASD and PTSD
- Grounding physical now required
- Consistent with USAF Waiver Guide, NCD up to 60 days
- After 60 days, CD and require waiver

➤ History of Alcohol Related Incident

- Still NCD but now require submission
- AMS + all supporting documents

➤ Alcohol Use Disorder

- Conflates old “Dependence” and “Abuse”
- No new requirements (but now more clearly listed)

Alcohol Waiver Guidance

- ARWG Section 14.2 “Alcohol Abuse or Dependence”
- “Psychiatric evaluation by a privileged psychiatrist or clinical psychologist” is required for waiver package
- AAC has approved acceptance of evaluations by privileged Licensed Clinical Social Workers (LCSW)

Alcohol Waiver Guidance

- Ideally, the psychiatric evaluation should be completed as close to the end of the 90-day post-treatment waiting period for waiver submission as possible
 - Minimize confounding effects of drinking
 - Minimize risk of over- and under-diagnosis
 - Pre-treatment evaluations are unacceptable

Alcohol Waiver Guidance

- Member must attend “an organized alcohol recovery program” (Alcoholics Anonymous, Birds of a Feather when eligible)
- Online AA meetings are NOT approved as alternative to F2F meetings
- The burden of proof for AA attendance is on the member and must be verified by the DAPA/SACO and flight surgeon

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Alcohol Waiver Guidance

- Contact NAMI Psychiatry for guidance regarding extenuating circumstances that may impact AA attendance

Alcohol Waiver Guidance

- The ARWG stipulates that the member must remain “abstinent without the need for Antabuse-type medications”
- In addition to disulfram (Antabuse®), this includes:
 - Naltrexone (either the oral form, Revia®, or injectable, Vivitrol®)
 - Acamprosate (Campral®)
 - Any “off-label” amethystic agent (e.g. topiramate [Topamax®])
- Medication effects aside, amethystic drug use by alcoholic aircrew suggests a more tenuous recovery than that of a “non-medicated” member

Alcohol Waiver Guidance

➤ Recommended waiting period for drug clearance:

- Antabuse® and Revia®: **2 weeks**
- Campral®: **4 weeks**
- Vivitrol®: **8 weeks**

Alcohol Waiver Guidance

- ✧ Command endorsement must be a separate document, on command letterhead, *not* merely a reference in the AMS
- ✧ Member statement should be more than a “copy and paste” from the ARWG, to document “unqualified acknowledgment” and “positive attitude” requirements

Initial Alcohol Waiver Package

- ✈ PE
- ✈ AMS
- ✈ Command Endorsement
- ✈ SARP Summary
- ✈ Psychiatric Evaluation
- ✈ Internal Medicine Evaluation (as indicated)
- ✈ DAPA Statement
- ✈ Member Statement

Years 2 & 3 Alcohol Waiver Package

- ✈ PE
- ✈ Psychiatric Evaluation
- ✈ DAPA Statement

Years 4+ Alcohol Waiver Package

✈ PE only

Flight Deck Personnel

- ✧ There is no rule that specifically disqualifies flight deck personnel from flight deck/line duties while on psychotropic pharmacotherapy
- ✧ Waivers "are determined locally by the senior medical department representative and commanding officer"

Flight Deck Personnel

- ✧ The SMO and CO need to be apprised of any flight deck personnel on psychotropic pharmacotherapy
- ✧ The Flight Surgeon and SMO can help the CO make informed decisions in granting any duty waivers for flight deck personnel on psychotropic medications on an individual basis

Flight Deck Personnel

- ✧ The Flight Surgeon should be particularly involved and aware of each individual's history, symptoms, treatment effectiveness, any adverse side effects, and actual compliance with the prescribed medicine regimen
- ✧ It is especially important for the Flight Surgeon to gauge any ongoing neurocognitive compromise secondary to the underlying treated condition OR the psychotropic medicine itself

AERO

- AERO is now well established for flight physical examinations and waiver package submissions via NAMI Physical Qualifications (Code 53HN)
- NAMI Code 53HN will likely send a prompt grounding notice if waiver packages are incomplete
- In the past, a package could be “held” until any missing/needed documentation was finally submitted by the flight surgeon – this accommodation may no longer exist

AERO

- All required waiver package documents should be included in AERO submission
- AMS/AERO statements requesting that NAMI reviewers “please see notes in AHLTA” are not acceptable
- This includes other relevant documents that may not be explicitly required by ARWG (e.g. AA meeting logs)

Waivers

→ “The Good, the Bad, and the Ugly”





The Good

- COMPLETE waiver packages
- All pertinent records included
 - Complete treatment records
 - Treatment summary letters are not enough
 - Legal records (e.g. DUI arrest reports)
- Clear date of remission
 - Critical to establishing waiver timeline
 - May entail close liaison with treating provider(s)



The Good

➤ Alcohol waiver packages with:

- Detailed AMS uploaded
- Command endorsement, on command letterhead, that reflects actual positive support and advocacy for the member (i.e., not just a one-line memo stating, "Forwarded, with approval")
- Member's waiver request letter is an actual letter per the ARWG that includes, but is not solely comprised of, the passage:
 - ***"I have read and received a copy of BUMEDINST 5300.8 series. I understand that I must remain abstinent. I must meet with my flight surgeon monthly for the first year, then quarterly for the next two years of aftercare. I must meet with the DAPA monthly and receive an annual mental health evaluation for the first three years of aftercare. And I must document required attendance at alcoholics anonymous (AA)."***



The Bad

- ✧ INCOMPLETE waiver packages
- ✧ Internally inconsistent waiver packages
- ✧ Aeromedical summary disregards or contradicts the actual psychiatric diagnosis by a mental health specialist
- ✧ No supporting records



The Ugly

- Alcohol waiver packages lacking verification of AA attendance
- DAPA statements with minimal and/or ambiguous information (e.g., “Member has been meeting aftercare requirements”)
- AMS says “please see AHLTA notes” for required medical records

Odds and Ends

✧ Judicious Medication Use

- Don't forgo if indicated (no effect on waiver timeline)
- Have an appropriate threshold

✧ FNAEB vs NAMI Psych Consult for NAA

✧ LBFS reminder: CANNOT clear Alcohol cases

- Or anyone who has (or SHOULD HAVE) grounding letter from BUPERS or CMC



AEROMEDICAL PSYCHOLOGY



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Questions?



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